THE RECOVERY KERNEL

DISCONTINUANCE PROTOCOL: GHB / GBL / 1,4-BD

The fastest, most unpredictable withdrawal in this series—and how to get through it safely.

Every other guide in this series has a point where it says 'this is uncomfortable but rarely dangerous.' This guide doesn't get to say that. GHB withdrawal, in anyone dosing more than three or four times daily, is a genuine medical emergency with a real risk of seizure, a specific and severe delirium, and death without proper management. This isn't dramatized for effect — it's the actual, documented clinical picture, and treating it with anything less than full seriousness is how people get hurt. This guide exists to make sure the seriousness translates into a plan, not just fear.

Section 0 — Immediate Safety: Read This First

EMERGENZA MEDICA

IF YOU ARE DOSING GHB, GBL, OR 1,4-BD MORE THAN THREE OR FOUR TIMES DAILY, DO NOT STOP WITHOUT MEDICAL SUPERVISION. WITHDRAWAL CAN BEGIN WITHIN 2-6 HOURS OF THE LAST DOSE, AND THE FIRST 12-72 HOURS CARRY A REAL, UNPREDICTABLE RISK OF SEIZURE AND A SEVERE DELIRIUM/PSYCHOSIS SYNDROME THAT CAN BE FATAL WITHOUT PROPER MEDICAL MANAGEMENT. GO TO AN EMERGENCY DEPARTMENT NOW IF YOU ARE A DEPENDENT USER PLANNING TO STOP, OR IF WITHDRAWAL HAS ALREADY BEGUN.

Signs that you are already in dangerous withdrawal — go to an ER now:

* ***Severe tremors or shaking.***
* ***High fever.***
* ***Seizures.***
* ***Hallucinations (seeing or hearing things that aren't real).***
* ***Suicidal thoughts.***
* ***Severe abdominal pain.***
* ***Confusion or disorientation.***

- Any seizure activity, however brief.
- Confusão, desorientação ou alucinações – isso pode se desenvolver rapidamente e não é o mesmo que ansiedade comum.
- Intensa agitación combinada con ritmo cardíaco acelerado, presión arterial alta o sudoración excesiva (inestabilidad autonómica).
- Tremor che si sta aggravando anziché rimanere stabile.

⚠ CAUTION

There is no reversal agent for GHB overdose, and there is no single FDA-approved medication for GHB withdrawal—unlike opioids (naloxone) or alcohol (benzodiazepines have a clear, standard protocol). This means the quality of care depends heavily on the treating physician's familiarity with GHB specifically. Section 8 of this guide exists to help you or someone supporting you advocate for the right treatment if the emergency team seems unfamiliar with it.

Section 1 — Why This Withdrawal Is Different From Every Other Guide in This Series.

What makes it different?	Why It Matters.
Tid av insättning.	GHB's plasma half-life is only 30-60 minutes. Withdrawal begins within 2-6 hours of the last dose in a dependent user — far faster than alcohol (6-24 hours) or benzodiazepines (12-48 hours). There is very little warning window between 'last dose' and 'danger.'
Imprevedibilità.	La gravità clinica non sempre corrisponde direttamente all'uso segnalato: una persona che sottostima il proprio uso o la cui fornitura ha una concentrazione incoerente (cosa estremamente comune con i precursori del GHB come GBL e 1,4-BD) può presentare sintomi molto più gravi di quanto previsto.
A distinct delirium and psychosis syndrome.	This isn't ordinary anxiety escalating. GHB withdrawal delirium involves agitation, confusion, visual hallucinations, and extreme autonomic instability — a genuine neurological emergency, distinct in character from alcohol's delirium tremens.
No standard treatment protocol.	Abstinência de álcool tem um protocolo bem definido e amplamente conhecido que envolve benzodiazepinas. A abstinência de opioides pode ser tratada com buprenorfina e metadona. A abstinência de GHB não tem tratamento específico aprovado pela FDA; a baclofeno (um agonista do GABA-B, o mesmo sistema de receptores em que o GHB age) é a opção mais embasada em evidências, mas muitos médicos de emergência têm pouca experiência direta com ela.

Section 2 — The Withdrawal Timeline

Timeline	What's happening?	What to Expect	What to Do
Hours 2-6 (Onset – the period for medical intervention).	GHB clears quickly, leaving GABA-B receptors without their ligand. Glutamate levels surge, and the HPA axis activates.	Anxiety, tremor, sweating, rapid heartbeat, nausea — the onset is fast and can be mistaken for ordinary anxiety until it escalates quickly.	This is when medical intervention (baclofen or benzodiazepines, Section 8) should begin if a dependent user is stopping. If you are

Timeline	What's happening?	What to Expect	What to Do
			not already under medical care and experiencing these symptoms: go to the emergency room immediately.
Hours 12-72 (Peak danger window)	Peak GABA-B receptor withdrawal; the period of highest risk for seizures, and the delirium/psychosis syndrome described in Section 1.	Kann im ersten Stadium noch starke Unruhe, Verwirrung, Halluzinationen und eine autonome Krise (beschleunigter Herzschlag, hoher Blutdruck, starkes Schwitzen) verursachen.	This window requires monitored medical care—inpatient or supervised detox, not home management—for anyone with a dependent use pattern.
Days 3-7	Akut farlig tilstand som avtar ved medisinsk behandling; GABA-B-systemet er fortsatt alvorlig svekket.	Kontinuierliche Angstzustände, Schlaflosigkeit und körperliches Unbehagen, auch wenn die akute Krise vorüber ist; weiterhin sorgfältige Überwachung erforderlich.	No sudden reduction of any bridging medication (baclofen or benzodiazepine) during this period—the tapering process should be gradual, as outlined in Section 8.
Weeks 1-4	Aumento de la actividad del receptor GABA-B; si aún está en curso, continuar con la reducción gradual bajo supervisión médica.	Lenta stabilizacja; fale lęku; powolna poprawa snu.	La pila completa di integratori inizia (Sezione 9). È anche in questa fase che i test genomici, se eseguiti, diventano utili (Sezione 5).
Months 1-3	Receptor de GABA-B: la recuperación está todavía en una fase temprana a media; este sistema se regula positivamente más lentamente que el receptor de GABA-A.	Ondas de ansiedad (un patrón de abstinencia post-consumo documentado específicamente para el GHB) que requieren una gestión activa, no solo esperar a que pasen.	Consistent breathwork, exercise, and the supplement protocol outlined in Section 9 are key factors that determine the severity of PAWS

Timeline	What's happening?	What to Expect	What to Do
			(Post-Acute Withdrawal Symptoms) episodes.
Months 3-12	La fase centrale di ripristino del GABA: generalmente da 3 a 6 mesi, più lunga rispetto alla maggior parte delle altre sostanze presenti in questa libreria.	Gradual, genuine improvement; PAWS symptoms lessening in both how often they occur and how severe they are.	Maintain every protocol. This is not a phase to reduce support prematurely.
Months 12-18+.	Substantial GABA-B receptor recovery reaching completion.	A truly distinct starting point – not simply the absence of symptoms, but a nervous system functioning with its own inherent regulation.	This is a genuine transformation, not merely the passage of time. It requires active effort and adherence to the protocols outlined in this guide, rather than passive waiting.

THE CENTURION

Observe how much longer this timeline runs compared to the benzodiazepine or methamphetamine guides in this series. The GHB Guide itself states this directly: "Unlike most other substances where the central phase is 4-8 weeks, GHB's GABA-B receptor upregulation is slower and more prolonged. The GABA restoration phase genuinely takes 3-6 months." Expecting benzo-guide or meth-guide timelines here will lead you to feel like recovery has failed when it's actually still on schedule.

Section 3 — How Long Until the Brain Is Actually Back to Normal.

The time it takes for the brain to fully recover after a traumatic event or substance abuse varies greatly depending on individual factors such as:

* **Age**
* **Overall health**
* **Severity of the trauma or substance use**
* **Genetics**
* **Access to quality treatment and support**

While some individuals may experience significant improvements within weeks or months, others may require years of dedicated recovery. It's important to remember that brain healing is a complex process, and there is no one-size-fits-all timeline.

[Table: Factors Affecting Brain Recovery Timeline]

Factor	Impact on Recovery Time
Age	Younger brains tend to recover faster than older brains.
Overall Health	Good overall health can promote faster healing.
Severity of Trauma/Substance Use	More severe trauma or substance use may lead to a longer recovery period.
Genetics	Genetic factors can influence brain resilience and recovery potential.
Treatment & Support	Access to quality treatment and support systems can significantly impact the speed and completeness of recovery.

It's crucial to consult with healthcare professionals for personalized guidance on the expected recovery timeline based on individual circumstances. They can provide accurate assessments, recommend appropriate interventions, and offer ongoing support throughout the healing process.

The honest answer here is longer than for any other substance in this series so far. The GABA-B receptor recovery that reaches substantial completion around months 12-18 is not simply symptom resolution — it represents the nervous system

rebuilding genuine endogenous regulation after having outsourced that regulation to a substance dosed every 2-3 hours around the clock, for however long the dependence lasted. That's worth sitting with directly: for someone dosing that frequently, GHB wasn't just a substance being used — it was functioning as the nervous system's external operating system. Rebuilding the internal one takes real time.

BEING HEARD

If you're at month 5 or 6 and still getting anxiety waves that arrive out of nowhere, that is not evidence the recovery isn't working — per the timeline above, you are exactly where the biology predicts you'd be. The finish line here is measured in over a year, not weeks. That's not a discouraging number. It's the honest one, and it means the waves you're still riding are expected, not a sign of failure.

Section 4 — What You'll Most Likely Experience

Beyond the acute medical emergency window in Section 2, the recovery period has a distinct texture worth naming directly.

- Ansiedade que surge em ondas, e não como um ruído de fundo constante — este é um padrão de abstinência pós-uso (PAWS) documentado específico para a recuperação do GHB, e não um sinal de risco crescente de recaída por si só.
- Sleep that is genuinely difficult to re-establish, especially for anyone who was taking medication overnight to manage sleep – the nervous system has to relearn how to fall and stay asleep without a GABA-B agonist doing that work externally.
- A specific kind of disorientation that isn't just emotional — for long-term, high-frequency users, the drug organized the literal structure of the day (the next dose was never more than a few hours away). Removing it can produce a temporal and identity disorientation on top of the neurochemical withdrawal — not just 'what do I feel' but 'what do I even do with my time now.'
- Sensibilidad autonómica que puede persistir más allá de la fase aguda: un ritmo cardíaco acelerado o sudoración en respuesta al estrés normal, lo que refleja la tormenta autonómica temprana de la abstinencia, pero con una intensidad mucho menor.

Section 5 — Genetic Cross-Reference

Gene	What It Governs	GHB Recovery Relevance
GABRA2	GABA-A receptor α-2 subunit — baseline inhibitory tone.	THE single most important gene for GHB vulnerability. High-risk variant carriers structurally run a lower-power baseline braking system, and GHB powerfully activates that

Gene	What It Governs	GHB Recovery Relevance
		underpowered system. This profile means slower GABA restoration, more severe PAWS, and non-negotiable (not optional) natural GABA-building practice — see Section 9.
GABBR1 / GABBR2	GABA-B receptor subunit genes – the primary receptor that GHB itself acts on.	The most directly relevant genes to GHB specifically, as distinct from GABRA2's relevance to benzos/alcohol. Variants here affect individual sensitivity to GHB and the severity of GABA-B receptor downregulation with chronic use. Testing availability is currently limited, but this is worth tracking as the field develops.
COMT (Val158Met)	Dopamin og stresskjemikalier fjerning.	Met/Met ('Sage,' slow clearance) is overrepresented in anxiety-driven GHB use — the drug's GABA-B anxiolysis relieving a chronically overstimulated system. Val/Val ('Warrior') appears more in chemsex/stimulant-adjacent use, with GHB functioning as the counterbalance to stimulant-driven anxiety. This determines recovery direction: Sage needs calm-building; Warrior needs stimulation-management.
MTHFR	Metilazione — sintesi dei neurotrasmettitori.	Creates baseline neurochemical deficits. GHB was partially addressing. 5-MTHF supplementation is foundational and often produces early, visible improvement. GHB also depletes B-vitamins through its own metabolic pathways, making methylation support urgent rather than optional in early recovery.
DRD2 / ANKK1 (Taq1A)	Densidade dos receptores de dopamina D2 — Síndrome da Deficiência de Recompensa.	Particularly relevant in chemsex and nightlife settings, where GHB's dopaminergic effects partially compensate for the RDS deficit. Recovery must rebuild the dopamine reward system directly; otherwise, the biological drive to resume GHB (or any dopaminergic substance) will persist.
SLC6A4 (5-HTTLPR)	Serotonin transporter expression.	Short/short carriers run high anxiety sensitivity, predisposing toward

Gene	What It Governs	GHB Recovery Relevance
		GABAergic substance use for anxiety management. Recovery needs to address the serotonin system alongside GABA — 5-HTP and 5-MTHF support both.
CYP2C19 / CYP3A4	Metabolismo de baclofeno y benzodiazepinas utilizadas en la desintoxicación de GHB.	Direkt relevant für Abschnitt 8 zur medizinischen Behandlung: Schlechte Metabolisierer akkumulieren Baclofen bei Standarddosen; sehr schnelle Metabolisierer benötigen möglicherweise höhere Dosen. Informieren Sie den behandelnden Arzt über jeden bekannten Status.
ADH1B / ALDH2	Metabolism of alcohol and 1,4-butanediol (1,4-BD).	Specifically relevant for 1,4-BD users — the ADH/ALDH pathway is what converts 1,4-BD into GHB in the liver. ALDH2*2 carriers who used 1,4-BD alongside alcohol face compounding conversion-pathway conflict and acetaldehyde toxicity accumulation; liver function testing is a priority for this specific subgroup.

Who's Actually Most at Risk — Putting the Genes Together

Who is most likely to develop dependence in the first place, and, separately, whose withdrawal and taper will be hardest once dependence exists?

Question	De genen die het antwoord geven.	Why?
People who use GHB frequently and in high doses are more likely to develop a dependence. Other factors that can increase the risk of GHB dependence include: * Having a history of substance abuse * Having a mental health condition, such as depression or anxiety * Taking other drugs, such as alcohol or benzodiazepines	GABRA2 high-risk + COMT Met/Met ('Sage').	This is the same 'Hard Fail' combination that the compendium identifies for GABAergic substances broadly: a structurally underpowered baseline braking system (GABRA2) combined with a chronically overstimulated, hard-to-quiet nervous system (Met/Met). GHB's rapid, complete anxiolysis is disproportionately compelling for exactly this profile — it's not that this person has less willpower, it's that GHB is

Question	De genen die het antwoord geven.	Why?
* Using GHB to self-medicate for physical or emotional pain		answering a louder, more specific biological question for them than it is for someone without this combination.
Withdrawal and tapering can be difficult for anyone, but some people may find it more challenging than others. This can depend on a number of factors, including: * The substance being withdrawn from * The length of time the person has been using the substance * The amount of the substance being used * The person's overall health and mental state * Whether or not the person has any underlying medical conditions People who are withdrawing from substances that affect the central nervous system, such as opioids or benzodiazepines, may experience more severe withdrawal symptoms. This is because these substances can have a significant impact on brain function. People who have been using substances for a long time, or who are using large amounts of the substance, may also experience more severe withdrawal symptoms.	GABRA2 high-risk + GABBR1/GABBR2 variants.	These are the receptor-level genes, not the motivation-level ones. GABRA2 determines general inhibitory reserve; GABBR1/GABBR2 determine sensitivity and downregulation severity at the exact receptor GHB acts on. This profile predicts a genuinely slower taper and more severe PAWS almost independent of the person's psychological relationship to the drug.

Question	De genen die het antwoord geven.	Why?
It is important to note that everyone's experience with withdrawal and tapering is different. Some people may be able to taper off substances relatively easily, while others may need more support. If you are considering withdrawing from a substance, it is important to talk to your doctor or other healthcare professional about the best way to do so. They can help you develop a plan that is safe and effective for you. Here are some additional resources that may be helpful: * [findahelpline.com](https://www.findahelpline.com/) * National Drug Strategy: https://www.health.gov.au/internet/main/publishing.nsf/content/drug-strategy * Australian Institute of Health and Welfare: https://www.aihw.gov.au/		

⚠ CAUTION

COMT genotype does not appear to determine whether a taper mechanically works — that's governed by the GABA receptor genes above, not by dopamine clearance speed.

What COMT actually determines is why someone used and what direction their post-taper recovery needs to point. A Met/Met ('Sage') profile tapering off GHB needs the taper itself managed the same way as anyone else with their GABRA2/GABBR status — but their longer-term recovery work is calm-building (the anxiety was there before GHB and needs a real answer). A Val/Val ('Warrior') profile, more often found in Chemsex/stimulant counterbalance use: requires stimulation management, focusing on genuine high-intensity outlets rather than simply calming activities. The tapering process remains the same, but the subsequent recovery goals differ.

Section 6 — Special Populations

Situation.	What makes it different?
Sodium oxybate prescribed for narcolepsy with cataplexy.	Sodium oxybate (pharmaceutical GHB) is the standard of care for this condition, and the dependence that develops is a necessary consequence of appropriate treatment, not a moral failure or a sign of misuse. Discontinuing it requires neurologist involvement, because the narcolepsy symptoms being managed will return on cessation. Alternative narcolepsy treatments (modafinil, armodafinil, solriamfetol, pitolisant) should be optimized before or alongside any reduction. This is a clinical decision for a specialist, never a self-managed taper.
GHB används som ett medvetet alkoholalternativ.	Some people use GHB explicitly to reduce drinking — trading one GABAergic substance for another with a different risk profile. GHB may carry lower organ toxicity than heavy alcohol use at moderate doses, but its dependence liability and overdose risk are severe in their own right. If this describes your situation, both dependencies may coexist, and a medical assessment of combined GABAergic dependence is essential before attempting any reduction of either substance.
Bodybuilding/athletic use for growth hormone stimulation.	GHB stimulates pituitary growth hormone release at low, non-recreational doses, and is used by some bodybuilders and athletes specifically for this effect — often taken nightly, framed as a recovery and muscle-building aid rather than as a party drug. This is a common and under-recognized starting point for GHB dependence precisely because it doesn't look like recreational drug use to the person doing it: it's taken alone, on a schedule, for a stated performance goal, which can delay recognizing the pattern as dependence forming until sleep has become chemically dependent on it. The nightly-dosing structure itself is the same mechanism. described in Section 1 and Section 4 — a habitual, scheduled dose is exactly how tolerance and physical dependence establish, regardless of the stated reason for taking it. Recovery needs to address the growth hormone axis directly rather than just the GABA system — natural GH-stimulating strategies (deep sleep architecture, appropriately timed fasting, HIIT training) replace the pharmacological approach; physician-guided GH-secretagogue

Situation.	What makes it different?
	peptides (such as ipamorelin) have been used as a bridge in some cases. This population also frequently needs a specific reframe: a supplement taken for a legitimate athletic goal becoming a dependence is not a different or lesser kind. de la adicción que cualquier otro en esta guía; la biología no se preocupa por las intenciones declaradas.
Dance festival and rave culture.	Historically, one of the most common ways people start using GHB is by taking a euphoric, sociable dose shared at a party or festival, often with MDMA, ketamine, or alcohol, to enhance the experience or ease the comedown from stimulants. This is also where Section 1's 'unpredictability' danger is most acute: GHB used at festivals and clubs is usually measured in capfuls poured from an unlabeled bottle, shared peer-to-peer with no way to know the actual concentration, on top of a person's own uncertainty about how much they've already had that night. Concentration inconsistency between one bottle. and the next is not a rare edge case in this context — it is close to the norm, which is a major reason GHB overdose events cluster heavily around festival and club settings specifically. The transition into dependence here often isn't a single dramatic moment; it's using between events to chase the same social ease or sleep support the festival dose provided, with frequency quietly climbing as festival season turns into a regular circuit. Alcohol co-use is also especially common in this specific context, given the setting — see Section 5's 'Hard Fail' combination note.
Livestreaming og innholdsproduksjon for sosiale medier.	A genuinely newer context, distinct enough to warrant its own category rather than being grouped under "nightlife." Using substances on camera, for an audience, introduces a second reward system layered directly onto the pharmacological one— real-time viewer attention and engagement activate the same dopaminergic reward circuitry that the substance itself is activating, and these can reinforce each other, potentially accelerating escalation compared to private use. This context also inverts the safety logic that the rest of this guide relies on: a bystander who is physically present can recognize an overdose and act — call for help, place someone in the recovery position, remove other substances from reach. An audience watching a livestream cannot do any of that. Visibility is not the same as safety, and a room full of viewers is, functionally, the same as being alone. Modern GHB or GBL is also increasingly delivered in disguised containers — energy drink bottles, sports drink bottles — sometimes by a third party rather than measured by the person using it themselves, which compounds Section 1's concentration-unpredictability danger with a second layer: not knowing what's actually in the bottle at all, on top. von nicht Kenntnis seiner

Situation.	What makes it different?
	Stärke.

BEING HEARD

There's a pattern worth naming that doesn't fit neatly into the table above because it isn't really about why someone uses GHB — it's about where. When a venue, a club, a friend group, or a community bans or excludes someone because of their use, the use itself very rarely stops. What changes is where it happens. A person who was using around other people — however imperfectly supervised, however far from ideal — often shifts to using alone, at home, specifically because the social settings that once absorbed the behavior no longer will. That shift from 'someone nearby who "Could help" to "no one around at all" is not a minor detail. It's the exact variable that determines whether an overdose is witnessed and survivable or silent. Exclusion, whatever its reasons, frequently trades a visible problem for an invisible and more dangerous one. If this describes your own history—a ban, a falling-out, a community that closed a door—that isolation was never a sign you were meant to handle this alone. It was a structural consequence of where the support went, not a verdict on whether you deserved any.

Section 7 — Use Pattern Classification

Most of this guide, out of necessity, addresses the most dangerous end of GHB use — because that end can kill, and getting that part right matters more than anything else here. But most people who use GHB are not at that end, and someone using once a week who simply wants to stop needs a genuinely different answer than 'go to an emergency department,' not just a thinner version of the same warning.

Level	Pattern	Risiko von Abhängigkeit/Entzugserscheinungen.	What Stopping Actually Requires: * Acknowledge the problem. * Seek professional help. * Build a support network. * Develop coping mechanisms. * Practice self-care. * Be patient and persistent. * Celebrate successes. * Learn from setbacks. * Stay connected to your support system. * Continue to seek professional help as needed.
1 — Rare / experimental	A handful of times total, no regular pattern.	Very low.	Physical dependence is essentially not a concern at this level. If you want to stop, you can simply stop. The main thing worth doing is understanding why it appealed to you (Section 6's context table) so a substitute pull doesn't quietly form somewhere else.
2 — Occasional / social	Aproximadamente una vez al mes o menos, relacionado con contextos específicos (fiestas, sexo con drogas, etc.), y que no aumenta con el tiempo.	Low.	For most people at this stage, stopping on their own is a reasonable goal. Keep an eye out for these signs: has the interval between uses become shorter? Has the amount used per session increased? If either of these is happening, you might be moving towards

Level	Pattern	Risiko von Abhängigkeit/Entzugserscheinungen.	What Stopping Actually Requires: * Acknowledge the problem. * Seek professional help. * Build a support network. * Develop coping mechanisms. * Practice self-care. * Be patient and persistent. * Celebrate successes. * Learn from setbacks. * Stay connected to your support system. * Continue to seek professional help as needed.
			Level 3 instead of staying at Level 2.
3 — Uso regular y recreacional, no dependiente.	Ongeveer wekelijks gebruik, stabiel en niet toenemend, geen nachtelijk gebruik, geen fysieke ontwenningsverschijnselen opgemerkt tussen de momenten van gebruik (geen trillingen, angstpieken of zweten voorafgaand aan het volgende geplande gebruik).	Moderate but generally manageable without medical detox.	This is the population most missing from most GHB material, including earlier drafts of this guide. Stopping is very likely safe to do without inpatient detox — but 'likely safe' isn't 'certain,' so a same-day conversation with a physician before stopping is still the responsible move, particularly to rule out dependence you may not have noticed forming. Section 9's Tier 1 and Tier 3 (nutrition and natural GABA support) are directly usable here, starting immediately rather than after a

Level	Pattern	Risiko von Abhängigkeit/Entzugserscheinungen.	What Stopping Actually Requires: * Acknowledge the problem. * Seek professional help. * Build a support network. * Develop coping mechanisms. * Practice self-care. * Be patient and persistent. * Celebrate successes. * Learn from setbacks. * Stay connected to your support system. * Continue to seek professional help as needed.
			medical detox phase.
4 — Escalating / dependence forming	La frequenza o il dosaggio è aumentato; si sono notati eventuali disturbi fisici tra le assunzioni (ansia, tremori, sonno interrotto), anche se non ancora giornaliere.	High and actively rising.	Questo è il livello in cui l'intervento del medico prima di interrompere smette di essere una precauzione facoltativa e diventa un vero requisito di sicurezza, anche senza uso quotidiano: l'escalation stessa è il segnale che il sistema GABA-B si sta adattando. Non aspettare il Livello 5 per richiedere assistenza medica.
5 — Dependent (the emergency threshold)	Tre volte al giorno, inclusa l'assunzione serale per gestire il sonno.	Severe — this is explicitly the threshold Section 0 identifies as a medical emergency requiring supervised	Do not attempt to stop without medical supervision under any circumstances. This protocol is written for people in the Population Section 8 program.

Level	Pattern	Risiko von Abhängigkeit/Entzugserscheinungen.	What Stopping Actually Requires: * Acknowledge the problem. * Seek professional help. * Build a support network. * Develop coping mechanisms. * Practice self-care. * Be patient and persistent. * Celebrate successes. * Learn from setbacks. * Stay connected to your support system. * Continue to seek professional help as needed.
		detox.	

SANCTUARY

If you're at Level 2 or 3 and reading this whole guide's emergency language, wondering if it applies to you—it's worth naming directly: it mostly doesn't, and that's a good thing, not a reason to dismiss the guide. The seriousness in Section 0 exists for Level 5, and it needed to be said clearly and first because that's where the mortality risk actually lives. But wanting to stop a weekly, non-dependent pattern is a completely legitimate reason to be here, and it doesn't require the machinery of Section 8 to do safely—mostly it requires the same. Consultation with a physician is essential for any significant changes, and the restorative processes outlined in Section 9 are effective regardless of whether you begin with a lower or higher initial level of health.

Accumulation d'une réserve : un facteur de risque indépendant du niveau de consommation.

This applies across every level in the table above, not just the dependent end: keeping a large stored supply on hand is its own distinct risk factor, separate from how often someone is actually using. Simple availability changes behavior — a large supply removes a natural point of friction that a smaller, harder-to-replace amount provides. In an already-intoxicated state, with judgment already affected, having more within reach makes an impulsive extra dose far easier than it would be if getting more required leaving, waiting, or making contact with someone. This is the same mechanism environmental redesign addresses elsewhere in the Recovery

Kernel (Compendium Protocol 05) — accessing it itself is part of the risk architecture, not just the substance.

⚠ CAUTION

The danger compounds specifically with GHB because of what Section 1 already establishes about concentration inconsistency. A large hoarded supply — especially GBL or 1,4-BD, or GHB from an unlabeled source — carries no guarantee that concentration stays consistent from the first measure to the last. Redosing repeatedly from the same large stockpile, already intoxicated and already less able to judge cumulative dose accurately, is a documented pattern behind escalation and overdose alike. A large supply on hand doesn't just make more use possible — it makes the specific kind of dosing error this entire guide exists to warn about. more likely.

If reducing or stopping is the goal at any level in the table above, reducing the accessible supply itself—not just the intention to use less—is a concrete, practical step worth taking on its own, separate from anything pharmacological.

Section 8 — The Medical Detox Protocol

This section exists to help you or someone supporting you advocate for the right care — GHB withdrawal management is genuinely underserved in emergency medicine, and knowing the options in advance can make the difference in what a treating team offers.

Approach	Mechanism.	Clinical Notes
Baclofeno, reducción gradual (preferible cuando esté disponible).	GABA-B agonist — works in the same way as GHB by binding to the receptor; a longer half-life means it can be gradually reduced over time.	The most pharmacologically rational approach. Doses required are often very high — up to 200-300mg/day — and must be carefully titrated. Not all emergency departments are familiar with baclofen for this specific use; you may need to advocate for it directly, citing the clinical literature (Addolorato et al. 2009; Bell et al. 2011) if met with unfamiliarity.
Protocola de altas dosis de benzodiazepinas (el más utilizado en la práctica).	GABA-A agonist — affects the GABA system generally, targeting a different receptor subtype than GHB's main target.	It's frequently used simply because it's familiar to emergency physicians. It's less pharmacologically specific than baclofen and may require very high doses to control severe withdrawal, with a real risk of transitioning into benzodiazepine dependence on top of the GHB recovery. Requires close medical monitoring.
Pharmaceutical	Substitución directa con la	The most theoretically elegant

Approach	Mechanism.	Clinical Notes
sodium oxybate taper.	misma molécula en una forma controlada y medida, seguida de una reducción gradual.	approach — same molecule, known pharmacokinetics, no guessing about supply concentration. Used in some specialist addiction units; availability is limited outside specific clinical contexts and requires a specialist addiction physician.
Fenobarbital.	Barbitúrico de acción prolongada con actividad agonista del receptor GABA-A; su vida media extremadamente larga (53-118 horas) proporciona niveles plasmáticos inherentemente estables y que se reducen gradualmente por sí solos.	Used in specialist settings for complex GABAergic polydrug withdrawal. Requires careful respiratory monitoring. Not first-line, but valuable in refractory cases.
Medications that provide support (used in addition to any of the above).	Clonidina pentru furtună autonomă; antipsihotice (haloperidol, quetiapină) pentru delir/halucinații; anticonvulsivante pentru prevenirea crizelor; fluide intravenoase și gestionarea electroliților.	GHB withdrawal causes severe autonomic instability, along with psychiatric symptoms. These additional treatments target the specific symptom clusters described in Section 1 and Section 2.

⚠ CAUTION

A note on active research: there is real, published toxicology research into monocarboxylate transporters (MCTs), which mediate GHB's renal reabsorption, and into whether urinary alkalinization (pH manipulation, including via sodium bicarbonate) can modestly enhance GHB renal elimination — the same underlying principle used clinically for salicylate overdose. A GABA-B antagonist (SCH-50911) has shown reversal effects in animal studies but has not been tested in humans. Both are described in the human proof-of-concept study cited in the literature as exactly that — proof of concept, not clinical practice. This is a genuine and active research frontier, worth knowing exists. It not a home intervention, not a substitute for the protocols above, and this guide will not walk through dosing or administration for either — that specific gap between 'the mechanism is real' and 'this is safe to do yourself, unmonitored' is exactly where people get hurt.

When hospital access is genuinely limited, consider these strategies:

**** **Prioritise urgent care:** Focus on addressing immediate and life-threatening conditions first.***
**** **Triage effectively:** Implement a robust triage system to identify patients with the most critical needs.***
**** **Optimise resource allocation:** Ensure resources are distributed efficiently to maximise their impact.***
**** **Communicate clearly:** Provide transparent communication to patients and families about wait times and potential delays.***
**** **Explore alternative care options:** Consider utilising telehealth, community-based services, or home healthcare where appropriate.***
**** **Collaborate with other providers:** Foster partnerships with local clinics, pharmacies, and specialists to expand access to care.***
**** **Advocate for policy changes:** Work towards systemic improvements that address the underlying causes of limited hospital access.***

Remember, seeking medical help is not failure. If you or someone you know requires urgent medical attention, do not hesitate to call for assistance. You can find support and resources at findahelpline.com.

Not everyone reading this can reach a hospital – because of distance, cost, immigration status, a country with limited emergency infrastructure, or a dozen other real reasons. That gap deserves a real answer, and the honest one isn't a self-administered protocol – it's making sure the resources that exist specifically for this situation actually get used.

What's Actually Available Without a Hospital	It's important because...
* **Over-the-counter medications:** These can help with minor aches, pains, and fever. Always follow the directions on the label. * **First aid supplies:** Bandages, antiseptic wipes, and pain relievers can be used to treat minor injuries at home. * **Telehealth services:** Many healthcare providers offer virtual consultations, which can be a convenient way to get medical advice without leaving your home. * **Urgent care centres:** These facilities provide walk-in care for non-life-threatening illnesses and injuries. * **Community health clinics:** These clinics often offer affordable or free healthcare services, including primary care, mental health support, and substance abuse treatment. * **Support groups:** Connecting with others who are facing similar challenges can be a valuable source of emotional support and practical advice. * **Online resources:** There are many websites and apps that provide information about health conditions, treatments, and self-care strategies. It's important to remember that medical help is not failure. If you're unsure	

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BEING HEARD

If you're reading this because a hospital genuinely isn't a realistic option for you, I want to say directly: that's a failure of the systems and circumstances around you, not something this guide can solve by handing you a protocol. What it can do is point you toward the phone-based resources that exist for exactly this gap, and toward acting earlier, while more doors are still open, rather than later when fewer are. That's a real answer, even if it isn't the one you were hoping for.

The 30-Day Cliff: A Second Relapse-Risk Axis That Discharge Planning Often Misses.

⚠ CAUTION

Un modello di dimissione comune merita di essere definito direttamente, perché crea una seconda finestra di pericolo distinta che non è la stessa della crisi di astinenza acuta descritta sopra: gestione ospedaliera per l'astinenza da GHB (spesso di circa 5 giorni), seguita dalla dimissione con una prescrizione di benzodiazepine, comunemente di circa 30 giorni, intesa come supporto mentre il sistema GABA-B si riprende. Quando quella scorta di 30 giorni finisce, c'è un'alta incidenza documentata di ricadute proprio in quel momento. Non è una questione di forza di volontà o di mancato rispetto del piano di dimissione. È un evento farmacologico prevedibile.

The reason maps directly onto Section 3's timeline: at day 30, GABA-B receptor recovery is still in its early phase — genuinely months away from the substantial recovery this guide's own data places at 12-18 months. The benzodiazepine bridge was never just treating symptoms during that window; it was providing GABA-A support partially compensating for a GABA-B system that has not rebuilt. When the prescription ends on a fixed calendar date rather than a clinical one — often with no taper, and often with no outpatient follow-up scheduled before the supply runs out — the person experiences a second withdrawal. event landing directly on top of a first one that was never actually finished. The chronic rebound anxiety and fear this produces is neurobiological, not primarily psychological, which is exactly why supportive therapy alone is frequently insufficient here: talk therapy is the right tool for a different problem than an unrecovered GABA-B receptor system generating genuine, physiologically-driven anxiety.

What Discharge Planning Often Gets Wrong	What Actually Reduces This Risk
* Lack of patient involvement: Patients and their families are often not actively involved in the discharge planning process, leading to a lack of understanding and buy-in. * Insufficient assessment: A thorough assessment of the patient's needs, including physical, emotional, and social factors, is crucial for effective discharge planning. However, this is often overlooked or inadequately addressed. * Inadequate coordination: Discharge planning requires seamless coordination between various healthcare providers, including doctors, nurses, therapists, and social workers. This coordination is frequently lacking, resulting in fragmented care and potential complications. * Limited resources: Insufficient access to community-based services, such as home health care, transportation, and support groups, can hinder a patient's ability to successfully transition from the hospital to their home environment. * Poor communication: Effective communication between healthcare providers, patients, and families is essential for ensuring a smooth discharge process. However, this communication is often inadequate, leading to misunderstandings and unmet needs. * Lack of follow-up: After discharge, it is crucial to monitor the patient's progress and address any emerging issues. This follow-up is frequently lacking, potentially resulting in readmissions or complications. * Ignoring cultural considerations: Discharge planning should take into	

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SANCTUARY

If you're nearing the end of a discharge prescription now, or if you've relapsed after one has expired, it's important to understand this clearly: what happened at that point was not a personal failure of willpower, and it doesn't negate any recovery progress made during your inpatient stay or the 30 days that followed. It was a predictable mismatch between the medication schedule and your body's natural processes. The appropriate response is the same as anywhere else in this guide when facing a real risk: seek medical support and develop a proper tapering plan, not a judgment. whether recovery is possible for you.

How This Can Become a Second, Separate Addiction

**** It can start as a way to cope with the withdrawal symptoms or cravings from the first addiction.***
**** It can provide a temporary escape from the negative emotions associated with the first addiction.***
**** It can become a new obsession that takes over your life.***
**** It can lead to other health problems, both physical and mental.***

If you are struggling with a second addiction, it is important to seek help. There are many resources available to help you get on the road to recovery. You can talk to your doctor, a therapist, or a support group. You can also find information and support online at findahelpline.com.

There's a specific pattern worth naming plainly, because it's less about the substance and more about what happens when nobody explains what's actually happening inside a person's own nervous system. Someone whose discharge benzodiazepine has run out is often still experiencing real, physiologically-driven anxiety — the direct product of a GABA-B system that, per Section 3, is nowhere near recovered. If nobody has told them this is what day 30 feels like and why, the natural conclusion is not 'this is expected post-GHB recovery.' It's 'I have an anxiety disorder' — a completely reasonable misread of a real symptom, made without the single piece of information that would fundamentally alter its proper management.

What often follows is a visit to a psychiatrist, sometimes with the GHB history disclosed and sometimes not — disclosure can feel harder than the symptom itself, given the stigma this library has already named elsewhere. A psychiatrist evaluating what presents as straightforward, severe anxiety, without the full context of a recent GABA-B withdrawal in progress, is often making a reasonable clinical call by prescribing a benzodiazepine. It isn't malpractice, and the person isn't necessarily lying — they're describing something genuinely severe and getting a response that matches what they described, minus the context that would have changed the response. This is the same pattern that the Recovery Kernel refers to elsewhere as "withdrawal framed as relapse": a temporary, biologically-driven post-acute symptom gets treated as a standalone, chronic condition, and the medication prescribed for the chronic version has no natural end date — because nothing in the visit suggested one was needed.

⚠ **CAUTION**

The result is a new, often longer-lasting dependence than the original one: a benzodiazepine prescribed indefinitely for what was actually a time-limited window of post-GHB neurological recovery. This is not a hypothetical risk — it is a documented pattern, and it deserves the same weight as the GHB dependence this entire guide addresses, because pharmacologically, it's the same trap in a different bottle.

What actually reduces this risk: disclosing the recent GHB history and withdrawal timeline to any psychiatrist or prescriber involved, even though it's uncomfortable, specifically because it changes what an informed prescriber would recommend. A prescriber who knows they're looking at post-GHB GABA-B recovery, not a new primary anxiety disorder, can reasonably offer a short-term, clearly time-limited bridge with a stated review date — the same accountability standard named elsewhere in this library for any substitute medication — rather than an open-ended prescription. The exact language worth using: 'This anxiety started after I stopped GHB about a month ago, and I understand that your nervous system may still be recovering from that, and I'd like any treatment we try to have a clear review date rather than being open-ended. That sentence alone can be the difference between building a genuine path forward and falling back into lifelong dependence.

Section 9 — The Recovery Protocol (Post-Acute)

⚠ **CAUTION**

This section starts after the period of an acute medical emergency (Section 0, hours 12-72 of Section 2), once a doctor has confirmed that the patient is medically stable. This does not replace Section 8; it follows after it.

Tier 1 — Biological Foundation (Day 1 post-detox onward)

Support	Role
Magnesium glycinate (400-600mg, in divided doses).	Support for GABA-A receptors and general nervous system calming – foundational, not optional, starting from Day 1.
P5P (active B6, 25-50mg)	Fattore coenzima per la conversione del glutammato in GABA (decarbossilasi del glutammato) — direttamente rilevante considerando l'aumento di glutammato nelle prime fasi dell'astinenza (Sezione 2).
5-MTHF (400mcg)	Support for foundational methylation, which is particularly important considering that GHB itself depletes B vitamins through its metabolic pathways.
L-teanina (200-400 mg, según sea necesario).	Non-sedating GABA/glutamate modulation for anxiety management, with no risk of dependence.

Tier 2 — Medical and Psychiatric Support

- Buspirona (agonista parcial de serotonina 1A no adictiva) para ansiedad persistente después de la desintoxicación: tarda de 2 a 4 semanas en hacer

efecto completo, es adecuada para la ansiedad prolongada de esta recuperación sin riesgo de dependencia de benzodiazepinas.

- Prova di 5-MTHF prima di considerare gli SSRI per la depressione in soggetti con variante MTHFR: valutare la risposta nell'arco di 4-8 settimane; gli SSRI rimangono appropriati se clinicamente indicati.
- Doses faibles de quétiapine (25-50 mg, durée limitée) peuvent améliorer la structure du sommeil en cas d'insomnie sévère liée à l'utilisation de GHB, lorsque les compléments alimentaires seuls ne suffisent pas. Ce n'est pas une option de première intention, mais c'est une possibilité réelle.

Tier 3 — Nervous System Regulation (Weeks 1-12, the central recovery phase).

- Esercizi di respirazione: da praticare quotidianamente, senza eccezioni, data la lunga durata del recupero dei recettori GABA-B descritta nella sezione 3.
- Cold exposure and yoga — both are directly relevant to building natural GABA levels.
- Consistency matters more here than intensity — per Section 2's timeline, this is a 3-6 month central phase, not a 4-8 week one. What determines PAWS severity is sustained practice through that entire window, not a strong first two weeks.

Exercise Specifics — Why cardio matters more here than in most other guides.

GHB withdrawal involves significant autonomic instability (Section 1, Section 2) — rapid heartbeat, fluctuating blood pressure, excessive sweating — and cardiovascular exercise is directly relevant to restoring the underlying bodily functions, rather than simply being a general health suggestion.

Type	What It Produces	Frequency.
Aerobic (running, cycling, swimming, brisk walking)	Endorfinas, serotonina, BDNF — e, especificamente relevante aqui, a normalização gradual do tônus autonômico em repouso (variabilidade da frequência cardíaca, pressão arterial basal) à medida que o sistema cardiovascular se recupera da tempestade autonômica da fase de abstinência.	3-5 sessions per week.
Strength training.	Dopamin, testosteron, hormón de crecimiento, BDNF: especialmente relevantes en el contexto del uso atlético/culturismo en la Sección 6, donde el efecto estimulante del GHB sobre la hormona del crecimiento fue parte del atractivo original y necesita un reemplazo genuino.	2-4 sessions per week.
Yoga.	Stimulering av det parasympatiska nervsystemet och direkte reduksjon av angst – en praksis som støtter GABA i seg selv, og ikke	1-3 sessions per week.

Type	What It Produces	Frequency.
	bare et tillegg til pusteøvelser.	
Daily walking.	La base fundamental que no es negociable: de fácil acceso, verdaderamente eficaz y adecuada incluso en los primeros días de recuperación y cuando la persona está más agotada.	Daily.

⚠ CAUTION

Timing and intensity matter, especially early on. Overtraining in the first weeks adds physiological stress on top of an already-taxed system rather than relieving it — start with walking and gentle movement, build toward the fuller program in months 1-3, and keep intense exercise out of the evening specifically, since it delays sleep onset in a recovery already fighting for sleep quality (Section 4).

Nutritional Support - Going beyond the basic four supplements.

Tier 1's four supplements are foundational, but they don't represent the complete picture. GHB use, especially heavy or long-term use, negatively impacts overall nutritional status. The nervous system, which is working on repair as described throughout this guide, needs the necessary building blocks to do so effectively.

- Consistent protein intake supports neurotransmitter synthesis broadly, including the GABA and dopamine systems; this entire recovery depends on it.
- Regelmäßige Essenszeiten sind im frühen Genesungsprozess genauso wichtig wie die Ernährung selbst – Blutzuckerschwankungen verstärken die bereits vorhandene Angst und Stimmungslabilität.
- Hydration and electrolyte support directly address the autonomic/sweating symptoms discussed in Section 2 and Section 4.
- La suplementación con vitaminas del grupo B, de forma amplia (no solo P5P y 5-MTHF), es relevante dado que el GHB en sí mismo agota esta familia de vitaminas; un complejo vitamínico B de alta calidad, junto con los elementos específicos de la categoría 1, es una adición razonable.

Losing Interest in the Drug: Natural GABA Reconstruction

Everything above manages symptoms and rebuilds biology. This part is about something different—actually wanting it less, not just tolerating its absence. GHB gave a specific thing: not partial relief, but a nervous system that would finally, completely stop. The premise here is that this exact state is genuinely reachable without it, through the brain's own systems, and that a reconstructed version is more sustainable than the pharmacological one ever was—because it doesn't downregulate the way GHB's receptor did.

Metodo di attivazione naturale.	The strength of the GABA effect can vary depending on several factors, including: * The specific type of GABA receptor involved. There are different subtypes of GABA receptors, each with its own unique properties and affinities for different drugs. * The concentration of GABA in the synapse. Higher concentrations of GABA will generally lead to a stronger effect. * The presence of other neurotransmitters or modulators. Other substances can either enhance or inhibit the effects of GABA. * Individual differences in receptor density and sensitivity. People may have varying numbers of GABA receptors, and these receptors may also differ in their responsiveness to GABA. Overall, the strength of the GABA effect is complex and	GHB-Recovery-Specific Notes

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BEING HEARD

This isn't about willpower, and it isn't a consolation prize for not having the drug anymore. What GHB was doing from the outside, a recovered system can genuinely do from the inside — that's not a hopeful reframe, it's the actual mechanism this whole guide has been describing. The state you're chasing was always a real, accessible nervous-system state. GHB was just one way to reach it — a fast, dangerous, downregulating way. The methods in this table reach the same place through a system that gets stronger with use instead of weaker.

Section 10 — Emergency Recognition, Restated

MEDICAL EMERGENCY

GO TO AN EMERGENCY DEPARTMENT IMMEDIATELY FOR:

* any seizure activity
* confusion, disorientation, or hallucinations
* extreme agitation with a racing heart, high blood pressure, or heavy sweating
* worsening tremor

This applies throughout the first 72 hours of cessation for any dependent user, and at any point afterward if these signs appear.

For anxiety waves, sleep difficulty, and the disorientation described in Section 4 without any of the above — these are expected per the timeline, and same-day contact with a physician is appropriate but this is not an ER-level emergency on its own.

Section 11 — Full Protocol Cross-Reference Map

Phase	Protocols.	Focus.
Medical Safety (Days 0-7 for dependent users)	Emergency department / inpatient detox — outside the Compendium's scope.	Prevención de convulsiones, protocolo de baclofeno o benzodiazepina, manejo del delirio, monitoreo de signos vitales. Esta guía, a partir de la Sección 9 y siguientes, solo se debe seguir una vez que esta fase esté completa desde el punto de vista médico.
Biological Foundation (Days 1-14 post-detox)	Compendium Protocols 07, 09, 17, 18.	Magnesium, vitamina B6, complejo de metilación, arquitectura del sueño, nutrición y reparación intestinal: condiciones esenciales para la recuperación del sistema GABA-B, no son complementos opcionales.
Genomic Mapping (Weeks 1-4)	Compendium Section 15, Protocol 11	Valutazione specifica del gene GABRA2: la scoperta genomica più importante per questa ripresa, che spiega la gravità della dipendenza, la gravità

Phase	Protocols.	Focus.
		dell'astinenza e la gravità della sindrome post-astinenza (PAWS).
GABA Restoration (Weeks 1-12, the central phase)	Compendium Protocol 04, Protocol 01 craving interrupt.	Breathwork, cold exposure, yoga, magnesium stack, anxiety management, sleep architecture — genuinely 3-6 months, not the 4-8 week timeline of most other substances in this library.
Behavioral and Environmental Architecture (Weeks 2-12)	Compendium Protocol 02, 05, 08, 13.	Cue removal, addiction transfer prevention, social architecture redesign — chemsex-context environmental triggers (venues, apps, social networks) are among the most potent cue-triggered craving environments documented; digital environment redesign matters as much as physical.
Chemsex Recovery, if applicable (Months 1-12)	Compendium Protocol 35S series, sexual health protocols.	Test para VIH/ITS e prevenção, saúde sexual na recuperação, construção de comunidade LGBTQ+ sóbria — veja a Seção 6 acima.
Identity and Meaning (Months 2-12)	Compendium Protocol 20, 21, 23, C-28.	When a strict dosing schedule, like one requiring medication every 2-3 hours, isn't the main way you organise your day anymore, it can mess with how you feel about time and who you are. This is what Section 4 talks about – feeling disoriented because of changes in routine.
The Long Game (Months 6-18+)	Compendium Protocol 24, 25, C-28, C-31.	Purpose architecture and a fully operational natural GABA system — as outlined in Section 3, this represents a real change that needs to be actively worked towards, rather than passively hoped for.

Section 12 — Closing

SANCTUARY

This is the hardest withdrawal in this entire series, and the recovery timeline is the longest — over a year to substantial completion, not weeks. That's not meant to discourage. It's meant to make sure the length of the road doesn't get mistaken, six months in, for the road going nowhere. A nervous system that outsourced its own regulation to a substance every two to three hours is capable of running that regulation itself again. It just takes the time the biology actually requires, not the time anyone wishes it took.

END OF GUIDE — DISCONTINUANCE PROTOCOL: GHB / GBL / 1,4-BD

Harm Reduction Resource — Not medical advice — Not a substitute for emergency care.

Crisis Resources: 988 (Suicide & Crisis Lifeline, call or text) | Crisis Text: HOME to 741741 | SAMHSA: 1-800-662-4357